Oroville Hospital	Job Description for Health Information Technician II	Department:	**Health Information Management**
		Dept.#:	**8700**
		Last Reviewed:	05/08; 08/12
		Last Updated:	

Reports to

Director of Health Information Management

Job Summary:

Under general supervision, the discharge processor will on a daily basis; file late laboratory, radiology, EKG reports and records by physicians and other health professionals; file completed charts away in terminal digit order, making sure that if the patient has more than one folder, all folders are filed away under the correct number with updated year band and with most current volume last.

Duties

1. The HIT II will on a daily basis; assemble charts of all discharged in and out patients in the prescribed fashion, making sure that each page carries the patient's name, hospital number and date of admission. Following the established order of assembly and filing protocol as referenced by facility policy and procedure; assembles the discharged inpatient medical record the day after discharge. Accurate assembly of an inpatient medical record consists of: accurate creation of medical record files, correct assembly order, creation of additional volumes as needed, as well as maintenance of the departmental production standard of discharged medical records.
2. Accurate analysis is accomplished by observation of policy and procedure. Assembled medical records are analyzed for deficiencies as defined by state and federal medical record requirements, and hospital policies. Deficiencies are tagged for completion and entered into the hospital software.
3. Completes scanning of the medical record documents after verifying all documents are completed in entirety as per facility policy and procedure.
4. Completes the photocopying, faxing and mailing of designated medical record reports to community providers at discharge in accordance with Release of Information policies and procedures.
5. Pulls and prepares medical records for hospital and medical staff requests. Delivers medical records to physicians and other medical staff as requested.
6. When pulling records for chart completion, the Health Information Technician, pulls charts using the most current Medical Record Deficiency by Provider printout. The oldest aged charts with a deficiency are priority.
7. When a staff member completes a medical record, the Health Information Technician is responsible for the accurate removal of the deficiency. Health Information Technician is responsible for verifying the removal of the deficiency against the printing of the medical staff member's deficiency list.

8. Using the computer entry software, performs weekly reanalysis of the discharged medical record. Reanalysis incorporates the following responsibilities; deleting or adding deficiencies, deficiency slip accuracy, verification that all reports and documentation belong to the patient, and assurance of accurate location of medical record including maintenance of terminal digit order.
9. Has a thorough working knowledge of HIPAA Privacy Practices and Release of Information policies and procedures and can assist patients and staff relative to HIM department responsibilities regarding authorizations, patient access, request for amendments, accounting of disclosures, and minimum necessary standards.
10. Begin an abstract on each discharge; and combine discharge with prior discharges for same patient in unit record folder, placing the appropriate colored tab to differentiate previous registration type
11. The HIT II will perform the initial quantitative chart analysis in addition to flagging physician, nursing and other health care professional's charting deficiencies
12. The HIT II will on a daily basis;
13. Review the thinned chart log for any charts needing to be thinned
14. Then go to the appropriate nursing floor and assemble the thinned portion of chart into the prescribed order and fasten with an Acco fastener
15. The log will then be marked as to the inclusive dates of hospitalization and the date thinned
16. The HIT II will on a daily basis; pull all charts for the next day's surgical schedule and place these charts on the surgery holding shelf; all charts will be signed out according to the chart sign-out procedure
17. Answer telephones, send charts and records to nursing floors and Emergency Room when needed
18. Assist physicians, nursing students and other hospital employees in patient care related activities and complete birth certificates accurately and with no errors to insure compliance with California State Law
19. Will assume other related responsibilities and duties as assigned

Qualifications

1. One year secretarial or stenographic experience with knowledge of filing procedures
2. Ability to understand and follow oral and written directions
3. Ability to establish and maintain working relationships with other employees, physicians and the general public
4. Valid Drivers License

Lifting Requirements

Light – generally lifting not more than 20 lbs. maximum with frequent lifting and/or carrying of objects weighing up to 10 lbs.